



Sen. Heather A. Steans

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1 AMENDMENT TO SENATE BILL 419

2 AMENDMENT NO. _____. Amend Senate Bill 419 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Findings. The General Assembly finds as
5 follows:

6 (1) It is in the best interest of the citizens of
7 Illinois to review and update Medicaid payment
8 methodologies to ensure the best use of public resources.

9 (2) The intent of the \$6.07 tax per occupied bed day
10 imposed by Public Act 96-1530 was to pay for increased
11 staffing under Public Act 96-1372.

12 (3) Many nursing homes are still staffed below the
13 legal level required under Section 3-202.05 of the Nursing
14 Home Care Act.

15 (4) Some low-staffed homes have gained from the higher
16 Medicaid rates but have not increased staffing.

17 (5) Policy research has noted the significant positive

1 relationship between nursing home staffing levels and
2 quality of care.

3 (6) The State of Illinois desires to pay for value and
4 quality not just volume.

5 (7) The use of regional wage adjusters rewards or
6 penalizes nursing homes solely on location and does not
7 account for staffing levels or actual wages paid.

8 Section 5. The Illinois Public Aid Code is amended by
9 changing Section 5-5.2 as follows:

10 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

11 Sec. 5-5.2. Payment.

12 (a) All nursing facilities that are grouped pursuant to
13 Section 5-5.1 of this Act shall receive the same rate of
14 payment for similar services.

15 (b) It shall be a matter of State policy that the Illinois
16 Department shall utilize a uniform billing cycle throughout the
17 State for the long-term care providers.

18 (c) Notwithstanding any other provisions of this Code, the
19 methodologies for reimbursement of nursing services as
20 provided under this Article shall no longer be applicable for
21 bills payable for nursing services rendered on or after a new
22 reimbursement system based on the Resource Utilization Groups
23 (RUGs) has been fully operationalized, which shall take effect
24 for services provided on or after January 1, 2014.

1 (d) The new nursing services reimbursement methodology
2 utilizing RUG-IV 48 grouper model, which shall be referred to
3 as the RUGs reimbursement system, taking effect January 1,
4 2014, shall be based on the following:

5 (1) The methodology shall be resident-driven,
6 facility-specific, and cost-based.

7 (2) Costs shall be annually rebased and case mix index
8 quarterly updated. The nursing services methodology will
9 be assigned to the Medicaid enrolled residents on record as
10 of 30 days prior to the beginning of the rate period in the
11 Department's Medicaid Management Information System (MMIS)
12 as present on the last day of the second quarter preceding
13 the rate period based upon the Assessment Reference Date of
14 the Minimum Data Set (MDS).

15 (3) Facility-specific staffing levels and wages paid.
16 ~~Regional wage adjusters based on the Health Service Areas~~
17 ~~(HSA) groupings and adjusters in effect on April 30, 2012~~
18 ~~shall be included.~~

19 (4) Case mix index shall be assigned to each resident
20 class based on the Centers for Medicare and Medicaid
21 Services staff time measurement study in effect on July 1,
22 2013, utilizing an index maximization approach.

23 (5) The pool of funds available for distribution by
24 case mix and the base facility rate shall be determined
25 using the formula contained in subsection (d-1).

26 (d-1) Calculation of base year Statewide RUG-IV nursing

1 base per diem rate, for dates of service beginning January 1,
2 2014 through June 30, 2017.

3 (1) Base rate spending pool shall be:

4 (A) The base year resident days which are
5 calculated by multiplying the number of Medicaid
6 residents in each nursing home as indicated in the MDS
7 data defined in paragraph (4) by 365.

8 (B) Each facility's nursing component per diem in
9 effect on July 1, 2012 shall be multiplied by
10 subsection (A).

11 (C) Thirteen million is added to the product of
12 subparagraph (A) and subparagraph (B) to adjust for the
13 exclusion of nursing homes defined in paragraph (5).

14 (2) For each nursing home with Medicaid residents as
15 indicated by the MDS data defined in paragraph (4),
16 weighted days adjusted for case mix and regional wage
17 adjustment shall be calculated. For each home this
18 calculation is the product of:

19 (A) Base year resident days as calculated in
20 subparagraph (A) of paragraph (1).

21 (B) The nursing home's regional wage adjustor
22 based on the Health Service Areas (HSA) groupings and
23 adjustors in effect on April 30, 2012.

24 (C) Facility weighted case mix which is the number
25 of Medicaid residents as indicated by the MDS data
26 defined in paragraph (4) multiplied by the associated

1 case weight for the RUG-IV 48 grouper model using
2 standard RUG-IV procedures for index maximization.

3 (D) The sum of the products calculated for each
4 nursing home in subparagraphs (A) through (C) above
5 shall be the base year case mix, rate adjusted weighted
6 days.

7 (3) The Statewide RUG-IV nursing base per diem rate:

8 (A) on January 1, 2014 shall be the quotient of the
9 paragraph (1) divided by the sum calculated under
10 subparagraph (D) of paragraph (2); and

11 (B) on and after July 1, 2014, shall be the amount
12 calculated under subparagraph (A) of this paragraph
13 (3) plus \$1.76.

14 (4) Minimum Data Set (MDS) comprehensive assessments
15 for Medicaid residents on the last day of the quarter used
16 to establish the base rate.

17 (5) Nursing facilities designated as of July 1, 2012 by
18 the Department as "Institutions for Mental Disease" shall
19 be excluded from all calculations under this subsection.
20 The data from these facilities shall not be used in the
21 computations described in paragraphs (1) through (4) above
22 to establish the base rate.

23 (e) Beginning July 1, 2014, the Department shall allocate
24 funding in the amount up to \$10,000,000 for per diem add-ons to
25 the RUGS methodology for dates of service on and after July 1,
26 2014:

1 (1) \$0.63 for each resident who scores in I4200
2 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

3 (2) \$2.67 for each resident who scores either a "1" or
4 "2" in any items S1200A through S1200I and also scores in
5 RUG groups PA1, PA2, BA1, or BA2.

6 (e-1) (Blank).

7 (e-2) For dates of services beginning January 1, 2014
8 through June 30, 2017, the RUG-IV nursing component per diem
9 for a nursing home shall be the product of the statewide RUG-IV
10 nursing base per diem rate, the facility average case mix
11 index, and the regional wage adjustor. Transition rates for
12 services provided between January 1, 2014 and December 31, 2014
13 shall be as follows:

14 (1) The transition RUG-IV per diem nursing rate for
15 nursing homes whose rate calculated in this subsection
16 (e-2) is greater than the nursing component rate in effect
17 July 1, 2012 shall be paid the sum of:

18 (A) The nursing component rate in effect July 1,
19 2012; plus

20 (B) The difference of the RUG-IV nursing component
21 per diem calculated for the current quarter minus the
22 nursing component rate in effect July 1, 2012
23 multiplied by 0.88.

24 (2) The transition RUG-IV per diem nursing rate for
25 nursing homes whose rate calculated in this subsection
26 (e-2) is less than the nursing component rate in effect

1 July 1, 2012 shall be paid the sum of:

2 (A) The nursing component rate in effect July 1,
3 2012; plus

4 (B) The difference of the RUG-IV nursing component
5 per diem calculated for the current quarter minus the
6 nursing component rate in effect July 1, 2012
7 multiplied by 0.13.

8 (e-3) Calculation of facility-specific RUG-IV nursing
9 component per diem rate for dates of service beginning July 1,
10 2017.

11 (1) The facility-specific RUG-IV nursing component per
12 diem rate must be the product of:

13 (A) The Statewide RUG-IV base rate of \$85.25.

14 (B) The staffing and wage adjuster which is
15 assigned per facility based on the facility's specific
16 total per resident per day staffing wage cost as
17 defined in paragraph (2) of this subsection. For levels
18 defined in paragraph (3) of this subsection, the
19 staffing wage adjuster is:

20 (i) 0.80 for a facility with a total per
21 resident per day staffing wage cost less than level
22 1, or a facility whose staffing level is below the
23 intermediate care minimum required under Section
24 3-202.05 of the Nursing Home Care Act even if the
25 facility has a total per resident per day staffing
26 wage cost greater than or equal to level 1;

1 (ii) 1.22 for a facility with a total per
2 resident per day staffing wage cost greater than or
3 equal to level 1 but less than level 2;

4 (iii) 1.42 for a facility with a total per
5 resident per day staffing wage cost greater than or
6 equal to level 2 but less than level 3;

7 (iv) 1.45 for a facility with a total per
8 resident per day staffing wage cost greater than or
9 equal to level 3; or

10 (v) 0.80 for a facility without data necessary
11 to calculate the facility's specific total per
12 resident per day staffing wage cost as defined in
13 paragraph (2) of this subsection.

14 (C) The facility weighted case mix, which is the
15 number of Medicaid residents as indicated by the
16 Minimum Data Set (MDS) data defined in paragraph (4) of
17 this subsection multiplied by the associated case
18 weight for the RUG-IV 48 grouper model using standard
19 RUG-IV procedures for index maximization.

20 (D) The ratio of actual staffing hours to total
21 expected staffing hours adjuster which is assigned
22 based on each facility's ratio as defined in paragraph
23 (5) of this subsection. The facilities are divided into
24 4 quartiles sorted from lowest to highest based on the
25 facility's ratio. The quartile with the lowest ratios
26 is quartile 1 and the quartile with the highest ratios

1 is quartile 4 with quartile 2 and quartile 3 assigned
2 based on the ratios in those quartiles in relation to
3 lowest and highest quartiles. Facilities without
4 reported data are assigned to quartile 3. The quartiles
5 are calculated quarterly during regular rate updates.
6 The adjuster for each quartile is as follows:

7 (i) 0.65 for facilities in quartile 1;

8 (ii) the ratio defined in paragraph (5) of this
9 subsection for facilities in quartile 2 and 3; or

10 (iii) 1.00 for facilities in quartile 4.

11 (2) The staffing and wage adjuster under subparagraph
12 (B) of paragraph (1) of this subsection must be updated
13 each quarter using the staffing hours and wage data from
14 Payroll Benefit Journal data collected by the Centers for
15 Medicare and Medicaid Services for the same time period of
16 MDS data used to calculate the RUG-IV acuity case weight.
17 For the purposes of this Section, each facility's "total
18 per resident per day staffing wage cost" is calculated by
19 summing:

20 (A) The product of registered nurses' hours worked
21 per resident day multiplied by the reported hourly
22 wage. For the Director of Nursing only the number of
23 hours allowed under Section 3-202.05 of the Nursing
24 Home Care Act for the calculation of staffing ratios
25 may be included; plus

26 (B) The product of licensed practical nurses'

1 worked hours per resident day multiplied by the
2 reported hourly wage; plus

3 (C) The product of certified nurse assistants'
4 hours worked per resident day multiplied by the
5 reported hourly wage; plus

6 (D) For all other staff considered direct care
7 staff under staffing ratios described in Section
8 3-202.05 of the Nursing Home Care Act, the product of
9 each remaining direct care staff type hours worked per
10 resident day multiplied by the reported hourly wage for
11 the direct care staff category at the same levels
12 allowed under the staffing ratios under Section
13 3-202.05 of the Nursing Home Care Act.

14 (3) The levels used to assign the staffing and wage
15 adjuster under subparagraph (B) of paragraph (1) of this
16 subsection shall be calculated using the staffing ratios
17 required under Section 3-202.05 of the Nursing Home Care
18 Act multiplied by the Illinois mean hourly wage for the
19 equivalent occupational code and title assigned by the U.S.
20 Bureau of Labor Statistics and reported in the May 2014
21 State Occupational Employment and Wage Estimates for
22 Illinois. The Department may, as established by rule, use
23 more current data from the same data set when made
24 available. The levels are:

25 (A) Level 1 is equal to the sum of:

26 (i) The product of 10% of the minimum staffing

1 hours per resident day for intermediate care under
2 Section 3-202.05 of the Nursing Home Care Act
3 multiplied by the Illinois mean hourly wage for
4 registered nurses occupation code 29-1141 from the
5 U.S. Bureau of Labor Statistics data set described
6 in paragraph (3) of this subsection; plus

7 (ii) The product of 15% of the minimum staffing
8 hours per resident day for intermediate care under
9 Section 3-202.05 of the Nursing Home Care Act
10 multiplied by the Illinois mean hourly wage for
11 licensed practical nurses occupation code 29-2061
12 from the U.S. Bureau of Labor Statistics data set
13 described in paragraph (3) of this subsection;
14 plus

15 (iii) The product of 75% of the minimum
16 staffing hours per resident day for intermediate
17 care under Section 3-202.05 of the Nursing Home
18 Care Act multiplied by the Illinois mean hourly
19 wage for nursing assistants occupation code
20 31-1014 from the U.S. Bureau of Labor Statistics
21 data set described in paragraph (3) of this
22 subsection.

23 (B) Level 2 is equal to the sum of:

24 (i) The product of 10% of the minimum staffing
25 hours per resident day for skilled care under
26 Section 3-202.05 of the Nursing Home Care Act

1 multiplied by the Illinois mean hourly wage for
2 registered nurses occupation code 29-1141 from the
3 U.S. Bureau of Labor Statistics data set described
4 in paragraph (3) of this subsection; plus

5 (ii) The product of 15% of the minimum staffing
6 hours per resident day for skilled care under
7 Section 3-202.05 of the Nursing Home Care Act
8 multiplied by the Illinois mean hourly wage for
9 licensed practical nurses occupation code 29-2061
10 from the U.S. Bureau of Labor Statistics set
11 described in paragraph (3) of this subsection;
12 plus

13 (iii) The product of 75% of the minimum
14 staffing hours per resident day for skilled care
15 under Section 3-202.05 of the Nursing Home Care Act
16 multiplied by the Illinois mean hourly wage for
17 nursing assistants occupation code 31-1014 from
18 the U.S. Bureau of Labor Statistics data set
19 described in paragraph (3) of this subsection.

20 (C) Level 3 is equal to the sum of:

21 (i) The product of .84 staffing hours per
22 resident day multiplied by the Illinois mean
23 hourly wage for registered nurses occupation code
24 29-1141 from the U.S. Bureau of Labor Statistics
25 data set described in paragraph (3) of this
26 subsection; plus

1 (ii) The product of .84 staffing hours per
2 resident day multiplied by the Illinois mean
3 hourly wage for licensed practical nurses
4 occupation code 29-2061 from the U.S. Bureau of
5 Labor Statistics data set described in paragraph
6 (3) of this subsection; plus

7 (iii) The product of 2.46 staffing hours per
8 resident day multiplied by the Illinois mean
9 hourly wage for nursing assistants occupation code
10 31-1014 from the U.S. Bureau of Labor Statistics
11 data set described in paragraph (3) of this
12 subsection.

13 (4) Minimum Data Set comprehensive assessments for
14 Medicaid residents on the last day of the quarter used to
15 establish the rate.

16 (5) The facility-specific total ratio of actual
17 staffing hours to total expected staffing hours for the
18 assigned resident specific case weight must be updated each
19 quarter using the staffing hours and wage data from Payroll
20 Benefit Journal data collected by the Centers for Medicare
21 and Medicaid Services for the same time period of MDS data
22 used to calculate the RUG-IV acuity case weight. For each
23 facility the Department must calculate the total hours
24 worked per resident day for direct care staff allowed by
25 the staffing ratios under Section 3-202.05 of the Nursing
26 Home Care Act and divide that value by the sum of staffing

1 hours per resident day assigned to each resident based on
2 the sum of the Resident Specific Time and Direct
3 Non-Resident Specific Time for the resident's RUG-IV
4 group. This is the same methodology for the Medicare 5-star
5 rating program calculation of the expected staffing hours
6 per resident day used by the Centers for Medicare and
7 Medicaid Services, except that the Centers for Medicare and
8 Medicaid Services uses RUG-III groupings.

9 (6) If the Payroll Benefit Journal data collected by
10 the Centers for Medicare and Medicaid Services is not
11 available, the Department must use the most recent cost
12 reporting data reported to the Department and the most
13 recent survey data posted to the Centers for Medicare and
14 Medicaid Services' Nursing Home Compare website. The
15 Department must use the Payroll Benefit Journal data
16 collected by the Centers for Medicare and Medicaid Services
17 once the data is available.

18 (e-4) Budget stability beginning July 1, 2017.

19 (1) Beginning July 1, 2017 and quarterly thereafter,
20 the Department may adjust, by administrative rule and
21 within the parameters established under this subsection
22 (e-4), the staffing and wage adjuster described in
23 subparagraph (B) of paragraph (1) of subsection (e-3) and
24 the ratio of actual staffing hours to the total expected
25 staffing hours adjuster described in subparagraph (D) of
26 paragraph (1) of subsection (e-3) for the purpose of

1 keeping liability created by the facility-specific RUG-IV
2 nursing component per diem rates stable as defined in
3 paragraph (2) and paragraph (3) of this subsection (e-4).

4 (2) Budget stability for facility-specific RUG-IV
5 nursing component per diem rates effective July 1, 2017
6 through June 30, 2019. If the aggregate budget stability
7 ratio calculated under paragraph (4) of this subsection is
8 greater than 0.96, then the Department must adjust one or
9 both of the adjusters specified in paragraph (1) of this
10 subsection in order to decrease the ratio to no less than
11 0.96.

12 (3) Budget stability for facility-specific RUG-IV
13 nursing component per diem rates effective July 1, 2019 and
14 quarterly thereafter. If the aggregate budget stability
15 ratio calculated under paragraph (4) of this subsection is
16 between 0.98 and 1.00, the Department must not make any
17 adjustments. If the aggregate budget stability ratio
18 calculated under paragraph (4) of this subsection is less
19 than 0.98, then the Department must adjust one or both of
20 the adjusters specified in paragraph (1) of this subsection
21 in order to increase the ratio to at least 0.98. If the
22 aggregate budget stability ratio calculated under
23 paragraph (4) of this subsection is greater than 1.00, then
24 the Department must adjust one or both of the adjusters
25 specified in paragraph (1) of this subsection in order to
26 decrease the ratio to at least 1.00, but no less than 1.00.

1 (4) For the purposes of this Section, the aggregate
2 budget stability ratio calculated with the numerator
3 described in subparagraph (A) of this paragraph (4) divided
4 by the denominator described in subparagraph (B) of this
5 paragraph (4) is as follows:

6 (A) Numerator equal to the sum of the following
7 products:

8 (i) the product of the number of Medicaid
9 residents in each nursing home as indicated in the
10 MDS data defined in paragraph (4) of subsection
11 (e-3) multiplied by 365; then multiplied by

12 (ii) each nursing home's specific rate under
13 paragraph (1) of subsection (e-3). This rate does
14 not include the per diem add-ons defined in
15 subsection (e) of this Section.

16 (B) Denominator equal to the sum of the following
17 products:

18 (i) the product of the number of Medicaid
19 residents in each nursing home as indicated in the
20 MDS data defined in paragraph (4) of subsection
21 (e-3) multiplied by 365; then multiplied by

22 (ii) each nursing home's specific rate
23 effective July 1, 2015 under subsection (e-2) as
24 adjusted by any past or future MDS validation
25 reviews performed by the Department. This rate
26 does not include the per diem add-ons defined in

1 subsection (e) of this Section.

2 (5) If adjustments are necessary under this subsection
3 (e-4), the staffing and wage adjuster described in
4 subparagraph (B) of paragraph (1) of subsection (e-3) must
5 be adjusted within the following parameters:

6 (A) the adjuster for facilities with a total per
7 resident per day staffing wage cost less than level 1
8 must never be greater than 0.80;

9 (B) the adjuster for facilities with a total per
10 resident per day staffing wage cost less than level 1
11 must be lower than the adjusters for the other levels;

12 (C) the adjuster for facilities with a total per
13 resident per day staffing wage cost less than level 1
14 must generate an aggregate cost coverage for nursing
15 homes qualifying for that adjuster less than or equal
16 to 70% using the most recent cost data from cost
17 reports filed with the Department. The cost coverage
18 for the nursing homes qualifying for that adjuster must
19 have the lowest cost coverage as compared to the other
20 3 groups;

21 (D) the adjusters for the middle 2 levels must
22 generate the best possible aggregate cost coverage for
23 nursing homes qualifying for those adjusters of all the
24 adjusters using the most recent cost data from cost
25 reports filed with the Department; and

26 (E) the adjuster for facilities with a total per

1 resident per day staffing wage cost greater than level
2 4 must generate an aggregate cost coverage for nursing
3 homes qualifying for that adjuster less than or equal
4 to 80% using the most recent cost data from cost
5 reports filed with the Department.

6 (F) Any limitations in this paragraph (5) based on
7 cost coverage must use the most recent cost data from
8 cost reports filed with the Department and must be
9 calculated after any adjustments have been made to the
10 ratio of actual staffing hours to total expected
11 staffing hours adjuster described in subparagraph (D)
12 of paragraph (1) of subsection (e-3) and limited by
13 paragraph (6) of this subsection (e-4).

14 (6) If adjustments are necessary under this subsection
15 (e-4), the ratio of actual staffing hours to total expected
16 staffing hours adjuster described in subparagraph (D) of
17 paragraph (1) of subsection (e-3) must be adjusted within
18 the following parameters:

19 (A) the adjuster for quartile 4 which has the best
20 acuity based staffing ratio must never be less than
21 1.00;

22 (B) the adjuster for quartile 1 must be the
23 smallest of all 4 quartile adjusters and must never be
24 greater than 0.65;

25 (C) the Department may set a specific adjuster for
26 quartile 2 and quartile 3 as opposed to the

1 facility-specific ratio defined in paragraph (5) of
2 subsection (e-3) which is allowed under subparagraph
3 (D) of paragraph (1) of subsection (e-3). If the
4 Department sets a specific adjuster for quartile 2 or
5 quartile 3, then the adjuster for quartile 3 must not
6 be greater than the adjuster for quartile 4 or less
7 than the adjuster for quartile 2. The adjuster for
8 quartile 2 must not be greater than the adjuster for
9 quartile 3 or less than the adjuster for quartile 1;
10 and

11 (D) no quartile may have an adjuster greater than
12 1.00.

13 (7) For the purposes of this Section, cost coverage for
14 a facility is the facility-specific RUG-IV nursing
15 component per diem rate divided by the healthcare program
16 cost per day. The healthcare program cost per day is
17 calculated using data from cost reports submitted to the
18 Department as required under the Illinois Public Aid Code
19 and the Department's administrative rules. The Department
20 may update the cost report references in this paragraph by
21 administrative rule should the Department's cost report be
22 altered, as long as the updated references result in
23 identification of the identical or equivalent data and does
24 not materially change the resulting calculations. If the
25 Department has made changes from an audit, the Department
26 may use column 10 instead of column 8 of the respective

1 cost report lines cited in this paragraph (7) if the
2 information is made publicly available at the time of
3 making any calculations required in this Section. The
4 healthcare program cost per day is the quotient of:

5 (A) the sum of the following costs as reported on
6 schedule V. of the Department's cost report;

7 (i) the total adjusted health care and
8 programs costs as reported on line 16 column 8;
9 plus

10 (ii) the total adjusted provider participation
11 fee costs as reported on line 42 column 8; plus

12 (iii) the total allocated cost of employee
13 benefits for health care employees calculated as
14 the total adjusted health care and programs salary
15 and wage costs as reported on line 16 column 1
16 divided by the product of the grand total salary
17 and wages as reported on line 45 column 1
18 multiplied by the total adjusted employee benefits
19 and payroll taxes as report on line 22 column 8;

20 (B) divided by the total patient days reported on
21 schedule III line 14 column 5 of the Department's cost
22 report.

23 (f) Notwithstanding any other provision of this Code, on
24 and after July 1, 2012, reimbursement rates associated with the
25 nursing or support components of the current nursing facility
26 rate methodology shall not increase beyond the level effective

1 May 1, 2011 until a new reimbursement system based on the RUGs
2 IV 48 grouper model has been fully operationalized.

3 (g) Notwithstanding any other provision of this Code, on
4 and after July 1, 2012, for facilities not designated by the
5 Department of Healthcare and Family Services as "Institutions
6 for Mental Disease", rates effective May 1, 2011 shall be
7 adjusted as follows:

8 (1) Individual nursing rates for residents classified
9 in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter
10 ending March 31, 2012 shall be reduced by 10%;

11 (2) Individual nursing rates for residents classified
12 in all other RUG IV groups shall be reduced by 1.0%;

13 (3) Facility rates for the capital and support
14 components shall be reduced by 1.7%.

15 (h) Notwithstanding any other provision of this Code, on
16 and after July 1, 2012, nursing facilities designated by the
17 Department of Healthcare and Family Services as "Institutions
18 for Mental Disease" and "Institutions for Mental Disease" that
19 are facilities licensed under the Specialized Mental Health
20 Rehabilitation Act of 2013 shall have the nursing,
21 socio-developmental, capital, and support components of their
22 reimbursement rate effective May 1, 2011 reduced in total by
23 2.7%.

24 (i) On and after July 1, 2014, the reimbursement rates for
25 the support component of the nursing facility rate for
26 facilities licensed under the Nursing Home Care Act as skilled

1 or intermediate care facilities shall be the rate in effect on
2 June 30, 2014 increased by 8.17%.

3 (j) The Department may adopt rules in accordance with the
4 Illinois Administrative Procedure Act to implement this
5 Section. However, the requirements under this Section must be
6 implemented by the Department even if the Department has not
7 adopted rules by the implementation date of July 1, 2017.

8 (k) The new rates under the reimbursement methodology
9 created by this amendatory Act of the 99th General Assembly
10 shall not be paid until approved by the Centers for Medicare
11 and Medicaid Services.

12 (Source: P.A. 98-104, Article 6, Section 6-240, eff. 7-22-13;
13 98-104, Article 11, Section 11-35, eff. 7-22-13; 98-651, eff.
14 6-16-14; 98-727, eff. 7-16-14; 98-756, eff. 7-16-14; 99-78,
15 eff. 7-20-15.)

16 Section 99. Effective date. This Act takes effect upon
17 becoming law.".